

Evidence for change of
birth date shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03788

CERTIFICATE OF DEATH

Reg. Dist. No. 106

FILM No. G 115 MAY 19 1948

1. PLACE OF DEATH:

County Charles
City or town Indian Head
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 yrs.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Charles
City or town Indian Head
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2. (a) If veteran, name war

3. (a) FULL NAME

Harriett Rockwood Beecher

3. (b) Social Security Number

4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife William Beecher
Aug. 1941 to 1948 6. (c) If alive, give age _____ years
7. Birth date of deceased (mo., day, yr.) Aug. 26, 1857

8. AGE: Years 90 Months 9 Days _____ It less than one day _____ hrs. _____ min.

9. Birthplace New Haven, Conn.
(Town, county, and state) Housewife

10. Usual occupation

11. Industry or business

12. Name Orvin Beers

13. Birthplace Utica, N. Y.

14. Maiden name Harrietta Rockwood

15. Birthplace East Orange, N. J.

16. Informant Anna Schuler
Address Tiennich, Ind.

17. Burial Burial Date thereof April 27, 1948
(Burial, cremation, or removal, Which?) (month) (day) (year)
Cemetery or crematory Bumpy Oak
Location Pompanoy, Ind.

18. Funeral director Chambers
Address Washington, D.C.
19. April 24, 1948 B. Day Price
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr. 24, 1948 at 5:30 P.
21. I CERTIFY that death occurred on the date above stated, that I attended deceased from family 19 48 to Apr. 24, 1948
and that I last saw him alive on Apr. 24, 1948
Immediate cause of death

arteriosclerosis, pulmonary edema
Due to In
Due to
Other conditions
(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

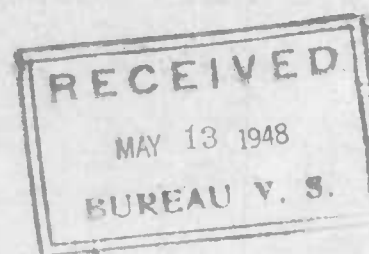
23. SIGNATURE Geo. C. Bisknell, M.D.
M. D. or other
Address Marbury, Ind. Date signed Apr. 24, 1948

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



Evidence for change of
birth date and age shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03789

FILM No. G 116 JUN 24 1948 CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH:

County Charles
City or town Rural - La Plata
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Charles
City or town Rural - La Plata
(If outside city or town limits, write RURAL and give nearest town)
Street No. Indian Head Road
(If rural, give LOCATION)
2. (a) If veteran, name war

3. (a) FULL NAME

Georgia L. Burroughs

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

Everett B. Burroughs

7. Birth date of deceased (mo., day, yr.)

August 7, 1899/1897

8. AGE:

Years 50 49 Months 7 Days 26 It less than one day
— hr. — min.

9. Birthplace

Washington, D.C.
(Town, county, and state)

10. Usual occupation

Homemaker

11. Industry or business

Henry Daugherty Jones
John Jones

FATHER

12. Name

John Jones

13. Birthplace

Washington, D.C.

MOTHER

14. Maiden name

Georgetta Jones

15. Birthplace

Washington, D.C.

16. Informant

Husband

Address

La Plata, Rural

17. (Burial, cremation, or removal. Which?)

Removal

Date thereof

4-4-48

Cemetery or crematory

La Washington, D.C.

Location

18. Funeral director

W.W. Chambers Co.

Address

517-1154 St. SE, Wash, D.C.

19. (Date rec'd by registrar)

4-4-48

Julia H. Gray

I Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

4 April

19 48 at 5:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

5 December 19 47 to 4 April 19 48

and that I last saw her alive on 4 April 48 19

Immediate cause of death Acute ventricular

failure, w. h.

DURATION

4 hrs.

Due to

Hypertension

12 yrs.

Due to

Arteriosclerosis

6 yrs.

Other conditions

none

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Injured at work?

Means of injury

23. SIGNATURE

J. Wooddy, M.D.

M. D. or other

Address

La Plata, Md.

Date signed 4 April 48

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 7 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03790

CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH:

County Charles
City or town Rural - Issue, Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? life long
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Md. County Charles
City or town Issue
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME

Ignatius Cornelius Burroughs

3.(b) Social Security Number

4. Sex Male 5. Color or race Colored. 6.(a) Single, married, widowed, or divorced married.
6.(b) Name of husband or wife Uirgin Johnson Burroughs
7. Birth date of deceased (mo., day, yr.) (61 years) 1887
6.(c) If alive, give age 52 years
8. AGE: Years 61 Months 8 Days — If less than one day — hrs. — min.

9. Birthplace Charles Co. Md.
(Town, county, and state)
10. Usual occupation Farmer
11. Industry or business

12. Name Madison Burroughs
13. Birthplace Chas. Co. Md.
14. Maiden name Margaret Hill
15. Birthplace Chas. Co. Md.

16. Informant Uirgin Burroughs
Address Issue, Md

17. Burial Date thereof 4-15-48
(Burial, cremation, or removal, Which?) (month) (day) (year)
Cemetery or crematory Wiley Street
Location Issue, Md

18. Funeral director Hewitt & Ryan
Address Waldorf Md

19. 4-13 19 48 Julia H. Ryan
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12 April 19 48 at 3:55 p.m.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2 April 48 to 12 April 48
and that I last saw him alive on 10 April 48
Immediate cause of death Cerebral vascular accident.
Due to hypertension
Due to senile vascular changes.
Other conditions —

DURATION
10 days.

4 years

years.

(Include pregnancy within 3 months of death)
Major findings of operations none
Date of op.

Autopsy results.
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide None Date of —
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE J. H. Woodward M. D. or other U.P.
Address La Plata, Md. Date signed 13 April 48.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 21 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03791

Reg. Dist. No. 104

1. PLACE OF DEATH:

County CHARLES
City or town NEWBURG
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 MONTHS
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Charles
City or town Newburg
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

GARLES JERIMAH BUTLER

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male Col. Single

6. (b) Name of husband or wife _____

7. Birth date of deceased (mo., day, yr.) Nov 8, 1947 6. (c) If alive, give age _____ years

8. AGE: Years Months Days If less than one day
5 9 _____ hrs. _____ min.

9. Birthplace Newburg - Charles Md
(Town, county, and state)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER
12. Name John Janet Butler
13. Birthplace Newburg Md
14. Maiden name Estelene Hattie Spe
15. Birthplace Newburg Md

16. Informant John Janet Butler
Address Newburg, Md

17. Burial, cremation, or removal. Which? Burial Date thereof 4-18-48
(month) (day) (year)

Cemetery or crematory Newburg

Location Newburg Md

18. Funeral director John Janet Butler
Address Newburg, Md

19. 4/18 1948 William F. Grebe
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH APR 17 1948, at 3 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4-16 1948, to 4-17 1948, and that I last saw him alive on 4-16 1948.

Immediate cause of death _____ DURATION

BRONCHOPNEUMONIA 2 DAYS

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Emmett Spencer J. M.D. M. D. or other

Address Bel Alton Md Date signed 4-18-48

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 21 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 106

1. PLACE OF DEATH:

County CharlesCity or town Marshall Hall
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 20 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County CharlesCity or town Marshall Hall
(If outside city or town limits, write RURAL and give nearest town)Street No. —
(If rural, give LOCATION)2. (a) If veteran, name war —

3. (a) FULL NAME

Herbert A. Dudley

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Aug, 28, 1880
6. (c) If alive, give age — years

8. AGE:

Years 67-~~7~~Months 7Days 15

If less than one day

— hrs. — min.

9. Birthplace

MD.
(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

FATHER

12. Name

William Dudley

13. Birthplace

MD.

MOTHER

14. Maiden name

Katherine Lavinia Toulson

15. Birthplace

Lynch, Robert Co. Md.

16. Informant

Mrs. Gertrude Pulliam

Address

Bryons Road, Md.

17.

(Burial, cremation, or removal, Which?)

Date thereof

4/14/48
(month) (day) (year)

Cemetery or crematory

Trinity Episcopal

Location

New Port, Md.

18. Funeral director

Huntt & Ryan

Address

Waldorf, Md.

19.

(Date rec'd by registrar)

19 48No. R. Howard

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 12, 1948 at 12:00 A.M.21. I CERTIFY that death occurred on the date above stated: that I attended deceased from onApril 12, 1948 to —and that I last saw him live on April 12, 1948

Immediate cause of death

Gunshot wound of brain

DURATION

Minutes

Due to

Suicide

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op. —

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Suicide Date of 4-12-48Where did injury occur? Marshall Hall, Charles, MD
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) HomeMeans of injury 38 revolver Injured at work? No

Deputy Medical Examiner

23. SIGNATURE James I. Mackenzie, M.D. M. D. or otherAddress Se. Plaza, Md. Date signed 4-12-48

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D. C. 20535

RECEIVED

MAY 13 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 100

03793

1. PLACE OF DEATH

County Charles
City or town La Plata
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Physicians Memorial Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Charles
City or town Farmers
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2. (a) If veteran, name war

3. (a) FULL NAME

Clarence

3. (b) Social Security Number

Fenwick

4. Sex M. 5. Color or race C 6. (a) Single, married, widowed, or divorced Single
6. (b) Name of husband or wife
6. (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Oct. 14, 1914
8. AGE: Years 33 Months 6 Days 13 If less than one day hrs. min.

9. Birthplace Wisconsin, Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name Leo Fenwick

13. Birthplace Chas. Co., Md.

14. Maiden name Mary Eliza Knott

15. Birthplace Chas. Co., Md.

16. Informant Josephine Short

Address Spring Hill, Md.

17. Burial Date thereof 4-30-48
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Marys

Location Newport

18. Funeral director Shaw & Ryan

Address Waldorf

19. 4-29 19 48 Julius H. Pusey
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-28 19 48 at 5 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4-25 19 48 to 4-28 19 48 and that I last saw him alive on 4-27 19 48

Immediate cause of death

Broncho-Pneumonia

DURATION

4-26-48

Due to Congestive Heart 4-10-48

Due to Systolic Failure

Other conditions Heart Disease

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

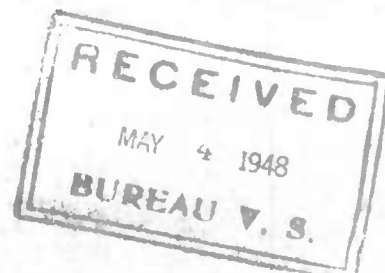
23. SIGNATURE [Signature] M. D. or other

Address La Plata Md. Date signed 4-28-48

MARGIN RESERVED FOR BINDING

VS 415 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 105

1. PLACE OF DEATH:

County... *Charles*
 City or town... *Rural Waldorf*
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infant, give residence of mother)

State... *md.* County... *Charles*
 City or town... *Rural Waldorf*
 (If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

Cora May Goldsmith

3. (b) Social Security Number

4. Sex

F

5. Color or race

W

6. (d) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Benjamin A. Goldsmith

7. Birth date of

deceased (mo., day, yr.)

March 16, 1876

8. AGE:

72

Years

21

Months

Days

If less than one day

hrs.

min.

9. Birthplace

Waldorf, Chas. Md.

(Town, county, and state)

10. Usual occupation

Housework

11. Industry or business

MOTHER

FATHER

12. Name

Thomas Langley

13. Birthplace

Chas. co. Md.

14. Maiden name

Priscilla Montgomery

15. Birthplace

Chas. co. Md.

16. Informant

Benjamin A. Goldsmith

Address

Waldorf, Md.

17. Burial

(Burial, cremation, or removal, Which?)

Cemetery or crematory

St. Marys

Location

Bryantown, Md

18. Funeral director

Waldorf & Ryon

Address

Waldorf, Md.

19. 4-8

(Date rec'd by registrar)

19. 48

W. L. Ward

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... *APRIL 6* 19... *48* at *6:20* A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

*MARCH 15*19... *48*to *APRIL 6*19... *48*

and that I last saw him/her alive on

*APRIL 5*19... *48*

Immediate cause of death

CEREBRAL HEMORRHAGE

DURATION

48 Hours

Due to

*HYPERTENSIVE CARDIO-
VASCULAR DISEASE**UNKNOWN*

Due to

*GENERALIZED ARTERIO-
SCLEROSIS**UNKNOWN*

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

John H. Griffin, M.D.

M.D. or other

Address

*NOCHESVILLE*Date signed *4/6/48*

RECEIVED

APR 9 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH:

County Charles
City or town La Plata
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 24 hrs.
Hospital, institution, or street address where death occurred:
Physicians Memorial Hospital
How long in hospital or institution? 24 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD. County Charles
City or town Indian Head
(If outside city or town limits, write RURAL and give nearest town)
Street No. 135 E. Wilson
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Infant Griffin

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Single
6.(b) Name of husband or wife
6.(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) April 2, 1948
8. AGE: Years Months Days If less than one day
1 → 24 hrs. 10 min.

9. Birthplace La Plata, Charles, Md.
(Town, county, and state)
10. Usual occupation Infant
11. Industry or business
12. Name Albert Henry Griffin
13. Birthplace Woodbridge, Va.
14. Maiden name Christina V. Nelson
15. Birthplace Woodbridge, Va.

16. Informant Mr. Albert H. Griffin (mother)
Address Indian Head, Md.
17. Burial Date thereof 4/4/48
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Family Plot
Woodbridge, Va.
Location Hunt & Pylon
18. Funeral director Wae for h. n. d.
Address Julie H. Paery
19. 4-3 19 48
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 3, 1948 at 2:10 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 2, 1948 to April 3, 1948
and that I last saw him alive on April 2, 1948
Immediate cause of death Thrombotic disease of newborn - type unknown
Due to
Due to
Other conditions Massive atelectasis
(Include pregnancy within 3 months of death)

DURATION
24 hrs.
24 hrs.

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?
23. SIGNATURE James J. MacKinnon, M.D.
Address La Plata, Md. Date signed 4-3-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 7 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

164C

03796

CERTIFICATE OF DEATH

Reg. Dist. No. 106

1. PLACE OF DEATH:

County Charles
 City or town Indian Head, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? One hour
 Hospital, institution, or street address where death occurred:
U.S. Naval Dispensary.
 How long in hospital or institution? Indian Head, Md.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Md. County Charles
 City or town Indian Head
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 11 D. Road, Perry Wright Project
 (If rural, give LOCATION)
 2.(a) If veteran, name war Indian Head, Md.

3. (a) FULL NAME

Lomuel Sylvester Hawkins

3. (b) Social Security Number

4. Sex Male 5. Color or race Col. 6.(a) Single, married, widowed, or divorced Married
 6.(b) Name of husband or wife Genevieve Hawkins
 6.(c) If alive, give age 30 years
 7. Birth date of deceased (mo., day, yr.) Jan. 6, 1910.
 8. AGE: Years 38 Months 3 Days 6 If less than one day
 ...hrs. ...min.

9. Birthplace Waldorf, Md.
 (Town, county, and state)
 10. Usual occupation Chauffer
 11. Industry or business U.S. Naval Powder Factory
 12. Name Pinkney Hawkins
 13. Birthplace Bryantown, Md.
 14. Maiden name Marie Frances Battles
 15. Birthplace Waldorf, Md.

16. Informant Mary Z. Smith
 Address Potsdam, Md.
 17. Buried Date thereof April 14, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)

X Cemetery or crematory St. Peter's
Waldorf, Md.
 X Location Hanft & Ryon
Waldorf, Md.
 18. Funeral director Hanft & Ryon
 Address Waldorf, Md.

19. 4-13 19 48 M.C. Mearns
 (Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 12 19 48 at 12:30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
 19... to 19...
 and that I last saw him... alive on 19...

Immediate cause of death Self-inflicted wounds chest
with internal hemorrhage
due to penetration of
section mediastinal blood
vessels.
 Due to Possible Blast (gas explosion) injuries.
 Other conditions None
 (Include pregnancy within 3 months of death)

Major findings of operations... Date of op. ...

Autopsy results...
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide Suicide Date of 4/11/48
 Where did injury occur? 11 D. Road, Perry Wright Project
Indian Head, Md. (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE Frank E. Susan, Jr., M.D.
 M. D. or other
 Address Indian Head, Md. Date signed 4-12-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

03797

CERTIFICATE OF DEATH

Reg. Dist. No. 106

1. PLACE OF DEATH:

County..... Charles
 City or town..... Pomonkey
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 5 yrs
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State..... MD County..... Charles
 City or town..... Pomonkey
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Mary Catherine Henson

3. (b) Social Security Number

4. Sex

Female

5. Color or race

Colored

6. (a) Single, married, widowed, or divorced

widowed

6. (b) Name of husband or wife

John Henson

7. Birth date of deceased (mo., day, yr.)

April 30, 1872

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

751113

hrs.

min.

9. Birthplace

Charles Co. Md.

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

Own Home

MOTHER

12. Name

George E Brown

13. Birthplace

Charles Co. Md.

14. Maiden name

Mary Catherine Brown

15. Birthplace

Charles Co Md.

16. Informant

Blanche Thomas

Address

806 R. I. Ave. N.W. Wash. D.C.

17.

Burial

Date thereof

4-16-48

(Burial, cremation, or removal. Which?)

Cemetery or crematory

St. Catherine Catholic

Location

McConchie Md.

18. Funeral director

Hunt & Pugh

Address

Waldorf Md.

19.

4-14

19

48 M. L. Thomas

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... April 13 1948 at 2 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... 1945 to April 13 1948
 and that I last saw h..... alive on April 13 1948

Immediate cause of death

Chronic Myocarditis

DURATION

3 yrs.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury

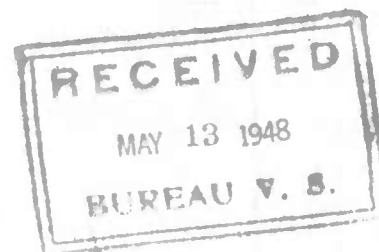
Injured at work?

23. SIGNATURE

Frank L. Susan M.D.

M. D. or other

Address..... Indian Head Md. Date signed.....



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03798

Reg. Dist. No. 282

1. PLACE OF DEATH:

County CharlesCity or town Hughesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County CharlesCity or town Hughesville
(If outside city or town limits, write RURAL and give nearest town)Street No. 6
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Mary Catherine Jackson

3. (b) Social Security Number

4. Sex

female

5. Color or race

white

6. (a) Single, married, widowed, or divorced

widowed

6. (b) Name of husband or wife

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.)

December 23, 1871

8. AGE:

Years

Months

Days

If less than one day

76327

hrs.

min.

9. Birthplace

Maryland
(Town, county, and state)

10. Usual occupation

none

11. Industry or business

MOTHER FATHER

12. Name

William Langley

13. Birthplace

Maryland

14. Maiden name

Blind Jackson

15. Birthplace

Maryland

16. Informant

Joseph B. Jackson

Address

Hughesville, Md.17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

4-23-48
(month) (day) (year)

Cemetery or crematory

St. Mary's

Location

Boysanton, Md.

18. Funeral director

D. B. Robinson

Address

Leonardtown, Md.19. 4/22

(Date rec'd by registrar)

19. 48

Registrar

Caiaulus

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 20 1948 at 2:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

October 1947 to April 20 1948and that I last saw her alive on April 20 1948

Immediate cause of death

Cardiac Failure

DURATION

2 weeks

Due to

Arterio-ScleroticHeart Disease4 years

Due to

Generalized Arterio-SclerosisUndetermined

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

John H. Griffin, M.D.

M. D. or other

Address

Hughesville

Date signed

4/21/48

RECEIVED

APR 26 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03799

Reg. Dist. No. 105

1. PLACE OF DEATH:

County Charles
 City or town Bryantown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 9 yrs
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State MD County Charles
 City or town Bryantown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Andrew Jamison

3. (b) Social Security Number

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Male White Married

6.(b) Name of husband or wife 6.(c) If alive, give age _____ years

Thelma M. Jamison7. Birth date of deceased (mo., day, yr.) Jan 11-1904

8. AGE: Years Months Days If less than one day

44 4 4 hrs. min.9. Birthplace Bryantown, Charles, MD
(town, county, and state)10. Usual occupation Farmer

11. Industry or business

12. Name John B. Jamison13. Birthplace Dentsville MD14. Maiden name Martha E. Bauman15. Birthplace Murford MD16. Informant Harriet JamisonAddress Bryantown MD17. Burial Date thereof 4-28-48
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St MarysLocation Bryantown MD18. Funeral director Hunt & RyanAddress Waldorf MD19. 4-27 1948 M. P. Moore
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 25 19 48 at 7:00 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

on April 25 19 48 to 19and that I last saw him on April 25 19 48

Immediate cause of death

Fracture-dislocation ofDue to suicidal spiritDue to HangingOther conditions Suicide

(Include pregnancy within 3 months of death)

Major findings of operations

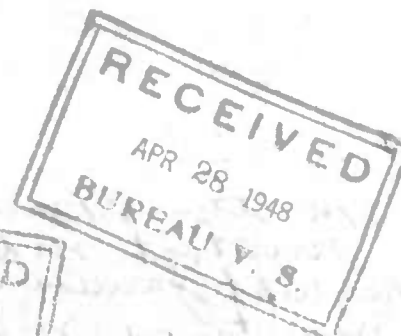
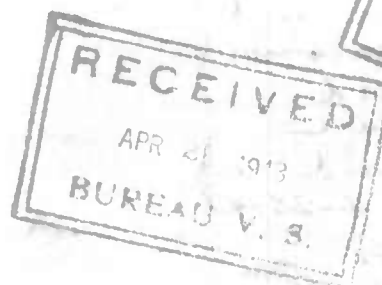
Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Suicide Date of 4-25-48Where did injury occur? Bryantown, Charles, MD
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) HomeMeans of injury Hanging Injured at work? No.23. SIGNATURE J. M. Kozak, M.D. M. D. or otherAddress Laurel Date signed 4-25-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 106

1. PLACE OF DEATH:

County Charles
 City or town Indian Head
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 19 years
 Hospital, institution, or street address where death occurred:
2 Strauss
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Md. County Charles
 City or town Indian Head
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 2 Strauss
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Lida Mann Lancaster

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
 6.(b) Name of husband or wife Christopher Lancaster
 6.(c) If alive, give age 66 years
 7. Birth date of deceased (mo., day, yr.) April 14, 1885

8. AGE: Years 62 Months 11 Days 21 If less than one day
 hrs. min.

9. Birthplace Bedford Va
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Own Home

12. Name Robert T. Mann

13. Birthplace N.Y.

14. Maiden name Mary Corbett

15. Birthplace Id

16. Informant Christopher Lancaster

Address Indian Head Md.

17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof April 8 1948
 (month) (day) (year)

Cemetery or crematory Cedar Hill

Location Washington D.C.

18. Funeral director J. W. Lee's Sons Funeral Home

Address 4th & Mass. Ave. N.E. Wash. D.C.

19. 4/7 48 Edy Price
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 6 1948 at 1 A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 5 1948 to April 6 1948 and that I last saw her alive on April 5 1948

Immediate cause of death Cerebral Hemorrhage DURATION 1 day

Due to Hypertension 20 yrs.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Frank H. Swan Jr.

M. D. or other

Address Indian Head Md Date signed 4-6-48

RECEIVED
MAY 13 1948
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Indicate correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

03801

106

1. PLACE OF DEATH:

County CharlesCity or town Indian Head
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 12 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County CharlesCity or town Indian Head
(If outside city or town limits, write RURAL and give nearest town)Street No. Glymont Rd.
(If rural, give LOCATION)2.(a) If veteran, name war Charles #1

3. (a) FULL NAME

Johan Gustave Middelthorn

3. (b) Social Security Number

72020

4. Sex

M.

5. Color or race

W.

6.(a) Single, married, widowed, or divorced

Married

6.(b) Name of husband or wife

Nettie K. Keid

7. Birth date of

deceased (mo., day, yr.)

April 2-1897

6.(c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

07016

hrs.

min.

9. Birthplace

Pa.

(Town, county, and state)

10. Usual occupation

Raceman

11. Industry or business

FATHER

12. Name

unknown

13. Birthplace

unknown

MOTHER

14. Maiden name

unknown

15. Birthplace

unknown

16. Informant

Nettie K. Middelthorn

Address

Glymont Rd. Indian Head

17.

(Burial, cremation, or removal. Where?)

Date thereof

April 27-48

Cemetery or crematorium

Wilmington Path

Location

Wilmington Va

18. Funeral director

W. K. Chambers Co.

Address

517-11 St. S.E.

19.

(Date rec'd by registrar)

19 48Odey Price

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

April 18 19 48 at 8:30 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 8 19 48 to only 19 48and that I last saw him alive on April 8 19 48

Immediate cause of death

Coronary Heart Disease

Due to

Myocarditis

Due to

Hypertension

Other conditions

Obesity wt. 250

(Include pregnancy within 3 months of death) ?

Major findings of operations

No operation

Date of op. —

Autopsy results

Not performed

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work? —

23. SIGNATURE

R. Moorman (M.D.)

M. D. or other

Address

Indian Head MdDate signed 4-18-48

4-19-48 Information on house side of this
Certificate was verified and appeared by
County Coroner. Signed.

Comdr. C. R. Moorman (M.C.) U.S.N.
Naval Powder Factory
Dispensary, Indian Head,
Md.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct use of this form is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03802

Reg. Dist. No. 100

1. PLACE OF DEATH

County CharlesCity or town Welcome
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County CharlesCity or town Welcome
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Ernsula H. Perry

3. (b) Social Security Number

4. Sex

F

5. Color or race

W

6.(a) Single, married, widowed, or divorced

Widowed

6.(b) Name of husband or wife _____

6.(c) If alive, give age _____ years

7. Birth date of

deceased (mo., day, yr.)

April 2, 1876

8. AGE:

Years

Months

Days

If less than one day

722626

hrs.

min.

9. Birthplace

Welcome, Chas Md
(Town, county, and state)

10. Usual occupation

Thief

11. Industry or business

MOTHER FATHER

12. Name

John P. Siffons

13. Birthplace

Chas. Co., Md

14. Maiden name

Clodia Franklin

15. Birthplace

Chas. Co., Md

16. Informant

Ses. V. Perry

Address

Welcome, Md

17.

(Burial, cremation, or removal)

Date thereof

(month) (day) (year)

Cemetery or crematory

St. Joseph

Location

Pomphret Md

18. Funeral director

Shirley L. Ryan

Address

Wesley, Md

19.

(Date rec'd by registrar)

19

4-30

19

48Julia H. Perry
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

4-28-48 at 9:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

3-6-48 to 4-28-48and that I last saw him/her alive on 4-26-48

Immediate cause of death

DURATION

Coronary Occlusion
Arterio Sclerotic Heart
Disease4-26-483-6-48

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

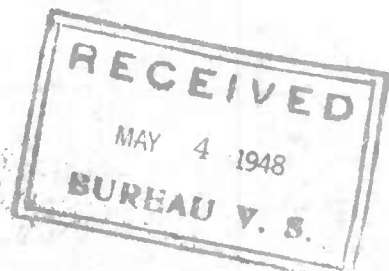
23. SIGNATURE

M. D. or other

Address

Date signed

Shirley L. Ryan M.D.
Wesley Md Date signed 4-28-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03803

Reg. Dist. No. 101

I. PLACE OF DEATH:

County... Charles
 City or town... Brookside
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Life
 Hospital, institution, or street address where death occurred:
—
 How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... MD County... Charles
 City or town... Brookside
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Philip Thomas Posey

3. (b) Social Security Number

4. Sex Male 5. Color or race Negro 6.(a) Single, married, widowed, or divorced Single
 6.(b) Name of husband or wife
 6.(c) If alive, give age years
 7. Birth date of deceased (mo., day, yr.) May 26, 1923
 8. AGE: Years 24 Months 10 Days 29 If less than one day hrs. min.

9. Birthplace... Brookside, Charles Md.
 (Town, county, and state)
 10. Usual occupation... Labourer
 11. Industry or business... Building Constructor
 12. Name... Archie Posey
 13. Birthplace... Brookside, Md.
 14. Maiden name... Carrie Marbury
 15. Birthplace... Brooklyn

16. Informant... Carrie Posey (mother)
 Address... Brookside, Md.
 17. Burial
 (Burial, cremation, or removal. Which?) Date thereof... April 29, 1948
 (month) (day) (year)
 Cemetery or crematory... Oak Grove
 Location... River Side Mol.
 18. Funeral director... Pennett & Opler
 Address... Mason Springs Mol.
 19. April 29, 1948 ms Ben Bowie
 (Date rec'd by registrar) (Signature of Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH... April 25 19 48 at about M
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
on Apr 25 19 48 to 19
 and that I last saw him on Apr 25 19 48

Immediate cause of death

Gunshot wound of chestDue to... Homicide

Due to.....

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

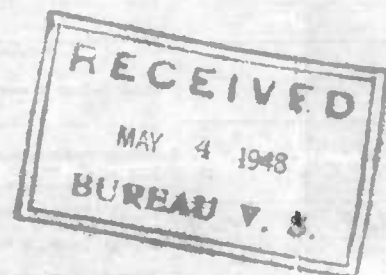
Accident, suicide, or homicide... Homicide Date of 4-25-48
 Where did injury occur? Brookside Charles, MD
 (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?) Public place
 Means of injury Revolver Injured at work? NO

23. SIGNATURE

James L. Montgomery, MD

M. D. or other

Address... Brookside, Md.Date signed 4-25-48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

03804

CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH:

County Charles
City or town Bel Air
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Charles
City or town Bel Air
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2. (a) If veteran, name war _____

3. (a) FULL NAME

Frank Proctor

3. (b) Social Security Number

4. Sex

M

5. Color or race

Col

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

1899

6. (c) If alive, give age _____ years

8. AGE:

Years

Months

Days

It less than one day

51

hrs. min.

9. Birthplace

Chas. co. md.
(Town, county, and state)

10. Usual occupation

Labourer

11. Industry or business

MOTHER FATHER

12. Name

Frank Proctor

13. Birthplace

Chas. co. md.

14. Maiden name

Cecilia Proctor

15. Birthplace

Chas. co. md.

16. Informant

Henry Proctor

Address

1337 - E St. S.E. Washington DC

17.

(Burial, cremation, or removal. Which?)

Date thereof

4/23/48
(month) (day) (year)

Cemetery or crematory

St. Ignace

Location

Bel Air, md

18. Funeral director

Hunt & Ryan

Address

Washington, md.

19.

4-23
(Date rec'd by registrar)19 48Julius H. Pacey
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 20 19 48 at 1 A M21. I CERTIFY that death occurred on the date above stated; that I attended deceased onand that I first saw him in on 19 48

Immediate cause of death

Coronary occlusion

Due to

Coronary artery disease

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Deputy Medical Examiner
J. E. McKeough, M.D.
La Plata, Md.

M. D. or other

Address La Plata, Md. Date signed 4-22-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 26 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 106

1. PLACE OF DEATH:

County Charles
City or town Indian Head
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 weeks
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State South Carolina County Newberry
City or town Newberry
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____
(If rural, give LOCATION)
2. (a) If veteran, name war _____

3. (a) FULL NAME

Edna Weeks Remsen

3. (b) Social Security Number

4. Sex F 5. Color or race W. 6. (a) Single, married, widowed, or divorced Widowed
6. (b) Name of husband or wife John S. Remsen
6. (c) If alive, give age _____ years
7. Birth date of deceased (mo., day, yr.) (?) 1869
8. AGE: Years 79 Months _____ Days _____ If less than one day _____ hrs. _____ min.

9. Birthplace Newberry South Carolina
(Town, county, and state)

10. Usual occupation House wife

11. Industry or business

FATHER 12. Name unknown
13. Birthplace "

MOTHER 14. Maiden name unknown
15. Birthplace "

16. Informant Mrs Alice L. Curtis

Address 1701, 16th St. N.W. Washington D.C.

17. Burial, cremation, or removal (Which?) Burial Date thereof 4/27/48
(month) (day) (year)

Cemetery or crematory Rosemont

Location Newberry South Carolina

18. Funeral director Hunt & Ryan

Address Waldorf Md.

19. 4-24 48 M. J. Moore
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 24 1948 at 6:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 19 1948 to April 23 1948 and that I last saw her alive on April 23 1948

Immediate cause of death Congestive heart disease DURATION 3 weeks

Due to Arteriosclerotic heart disease 10 years

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

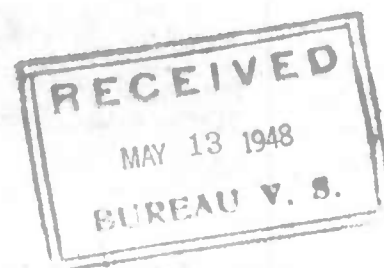
23. SIGNATURE J. H. O'Donoghue M.D.
Address 103-5 Spruance Avenue Indian Head Date signed 4/24/48

MARGIN RESERVED FOR BINDING

9-45-15M

VS-415

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



Evidence for change of
age shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

FILM No. G 115 APR 22 1948 CERTIFICATE OF DEATH

Reg. Dist. No. 03806
100
284

1. PLACE OF DEATH:

County Charles
City or town Hughesville Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 years
Hospital, institution, or street address where death occurred:
Hughesville Charles Co Maryland
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Charles
City or town Hughesville
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____
(If rural, give LOCATION)
2. (a) If veteran, name war _____

3. (a) FULL NAME

Annie Elizabeth Roache

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widow
6. (b) Name of husband or wife John M Roache
7. Birth date of deceased (mo., day, yr.) April 23 - 1875
6. (c) If alive, give age _____ years
8. AGE: Years 73 Months 72 Days 11 If less than one day _____ hrs. _____ min.

9. Birthplace St Marys Co., Md.
(Town, county, and state)

10. Usual occupation House wife

11. Industry or business

12. Name Joseph Jenkins
13. Birthplace St Marys Co
14. Maiden name Rachel Wheatley
15. Birthplace St Marys Co

16. Informant Jos H. Roache

Address Hughesville Maryland

17. Burial Date thereof April 19 - 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St Marys Cemetery

Location Burgantown Charles Co Md

18. Funeral director W C Mattingly Sons

Address Leonardtown Maryland

19. April 16 19 48 2 Edward S. Carter
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 15 19 48 at 1:30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 1 19 47 to April 14 19 48
and that I last saw him alive on March 31 19 48

Immediate cause of death Acute Cardiac Failure

DURATION
1 HOUR

Due to Hypertensive Cardio-vascular Disease 5 years

Due to Generalized Arteriosclerosis Hypertension

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

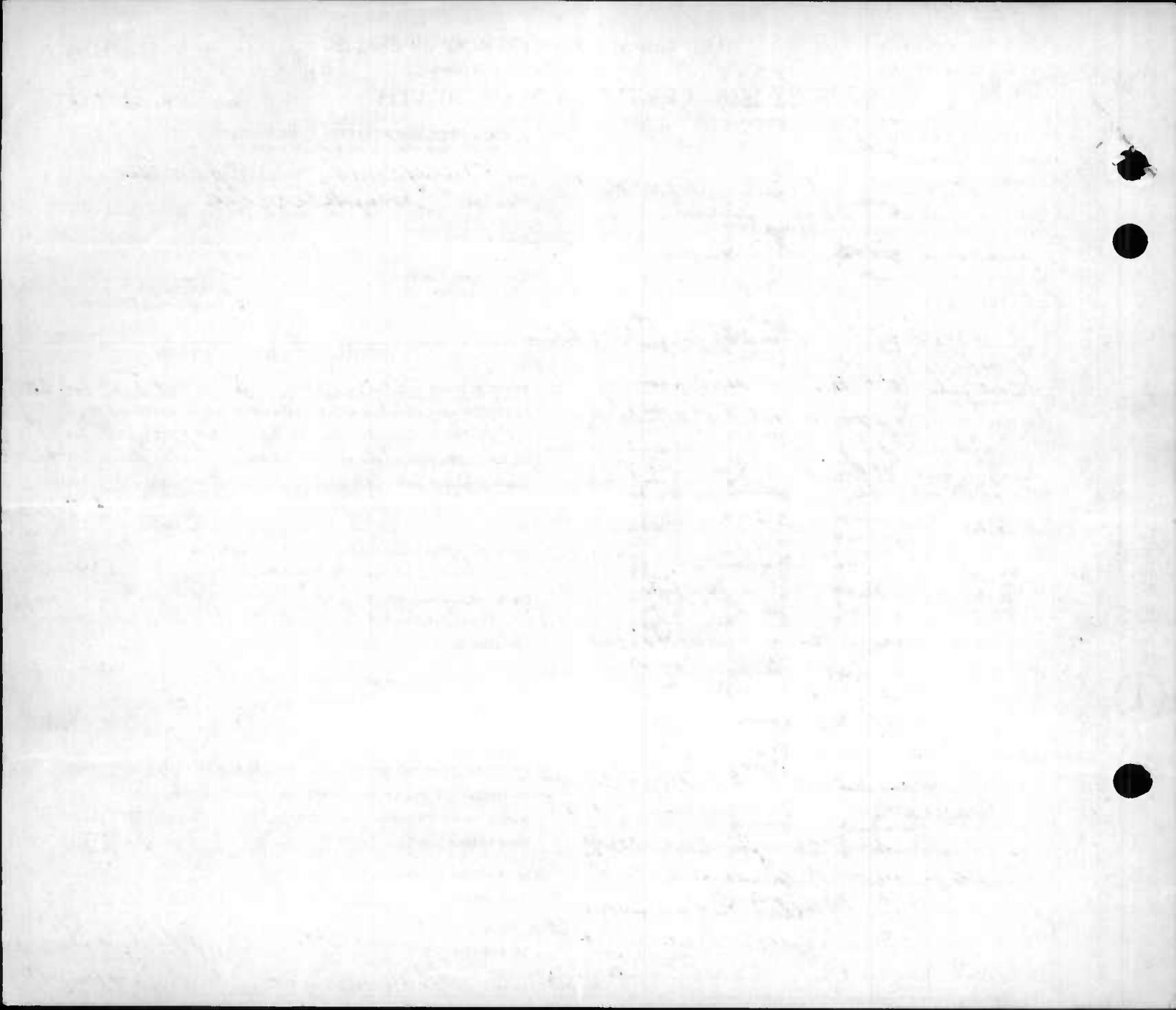
Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of Injury _____ Injured at work? _____

23. SIGNATURE John H. Griffin, M.D. M. D. or other _____

Address HUGHESVILLE Date signed 4/16/48



03807

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 101

1. PLACE OF DEATH:

County..... Charles
 City or town..... Innosides
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... Life time
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)
 State..... Maryland County..... Charles
 City or town..... Innosides
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2. (a) If veteran, name war.....

3. (a) FULL NAME

Frances Marion Simmone

3. (b) Social Security Number

4. Sex..... F 5. Color or race..... W 6. (a) Single, married, widowed, or divorced..... Widowed
 6. (b) Name of husband or wife..... Thos. P. Simmone
 7. Birth date of deceased (mo., day, yr.)..... Dec. 21 1858 6. (c) If alive, give age..... years
 8. AGE: Years..... 89 Months..... 4 Days..... 3 If less than one day..... hrs..... min.

9. Birthplace..... Perry, Charles Co. Md.
 Town, county, and state10. Usual occupation..... Housewife

11. Industry or business.....

12. Name..... Elizabeth Bourie13. Birthplace..... Charles Co. Md.14. Maiden name..... FRANCES MARION BOURIE15. Birthplace..... Perry, Charles Co. Md.16. Informant..... Marie MitchellAddress..... Innosides, Md.17. Burial Date thereof..... Apr 26 1948
 (Burial, cremation, or removal, which?) (month) (day) (year)Cemetery or crematory..... BaptistLocation..... Waldorf, Md.18. Funeral director..... Waldorf, Md.

Address.....

19. 4-26 1948 Mary Smithland
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Apr. 24 1948 at 1 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
April 19 47 to Apr 24 19 48and that I last saw him alive on..... Apr 23 19 48

Immediate cause of death.....

Incompetence of age.Cardiac-renal disease.

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... George C. Bicknell M.D.Marbury Md M. D. or otherAddress..... Date signed..... Apr 26 48

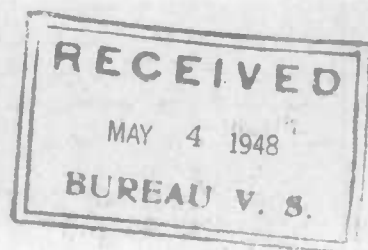
MARGIN RESERVED FOR BINDING

I

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. 1. For correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 03808 105

1. PLACE OF DEATH:

County... Charles
 City or town... Bryans Road
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?... 6 yrs
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution?... —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... MD County... Charles
 City or town... Bryans Road
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war... _____

3. (a) FULL NAME

Evelyn Pauline Weeks

3. (b) Social Security Number

4. Sex... Female 5. Color or race... White 6.(a) Single, married, widowed, or divorced... Single
 6.(b) Name of husband or wife... _____
 6.(c) If alive, give age... _____ years
 7. Birth date of deceased (mo., day, yr.)... Febr. 22 1926
 8. AGE: Years... 22 Months... 2 Days... 0 If less than one day... _____ hrs. _____ min.

9. Birthplace... Wananton, Va.
 (Town, county, and state)

10. Usual occupation... None

11. Industry or business... _____

12. Name... Albert Weeks
 13. Birthplace... Wananton, Va.
 14. Maiden name... Susan Riley
 15. Birthplace... Prince William, Va.

16. Informant... Mr. Albert Weeks
 Address... Bryans Rd, Md.

17. Buried Date thereof... 4-24-48
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory... Marlbury Baptist
 Location... Marlbury Md
Hemitt & Ryer

18. Funeral director... Wal doy sm
 Address... _____

19. 4-24 19 48 M W. H. H. H.
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... April 22, 1948 at 12 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from on April 22, 1948 to 1948 and that I saw him on April 22, 1948

Immediate cause of death... Status epilepticus

Due to... Idiopathic epilepsy

Due to... _____

Other conditions... _____
 (Include pregnancy within 3 months of death)

Major findings of operations... _____
 Date of op. _____

Autopsy results... _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide... _____ Date of... _____
 Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____

23. SIGNATURE... John L. McKavanagh, M.D. M. D. or other
Deputy Medical Examiner
La Plata, Md. Date signed... 4-22-48

